

Rapid Review of the literature: Assessing the infection prevention and control measures for the prevention and management of COVID-19 in health and care settings

Version 8.0

5 November 2020

Version history

Version	Date	Summary of changes
1.0	19/3/2020	Assessment of the emerging COVID-19 evidence base, includes literature identified up to 16 March 2020.
1.1	3/4/2020	Assessment of the emerging COVID-19 evidence base, includes literature identified up to 30 March 2020.
1.2	20/4/2020	Assessment of the emerging COVID-19 evidence base, includes literature identified up to 13 April 2020.
3.0	15/5/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 11 May 2020.
4.0	24/6/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 15 June 2020.
5.0	23/7/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 20 July 2020
6.0	2/9/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 31 August 2020
7.0	2/10/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 28 September 2020
8.0	05/11/2020	Monthly assessment of the emerging COVID-19 evidence base, includes literature identified up to 02 November 2020

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Abbreviations

ABHR	Alcohol based hand rub
AGP	Aerosol-generating procedure
FFP2	Filtering face piece respirator (class 2)
FFP3	Filtering face piece respirator (class 3)
FRSM	Fluid-resistant surgical face mask
HDU	High dependency unit
HPS	Health Protection Scotland
ICU	Intensive care unit
ITU	Intensive therapy unit
MERS-CoV	Middle East respiratory syndrome coronavirus
NIPCM	National Infection Prevention and Control Manual
NERVTAG	New and Emerging Respiratory Virus Threat Assessment Group
PPE	Personal protective equipment
RPE	Respiratory protective equipment
SARS-CoV	Severe acute respiratory syndrome coronavirus
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
WHO	World Health Organization

1 Aim

To provide a rapid review of the scientific evidence base to inform the infection prevention and control measures required for the prevention and management of COVID-19 in health and care settings.

2 Objectives

Objectives for the rapid review were to establish the following:

- The epidemiology of COVID-19;
- The personal protective equipment (PPE) requirements;
- The requirements for hand hygiene;
- The environmental survivability of COVID-19;
- The requirements for cleaning/decontamination of the care environment;

3 Methodology

As this was a rapid review, evidence was critiqued but not formally graded with the use of an appraisal tool. Screening and critical appraisal was undertaken by two reviewers. Academic databases (Medline and Embase) were searched on 5th March 2020 to identify relevant literature and additional hand searching was conducted. See [Appendix 1](#) for search strategies.

3.1 Evidence updates

The emerging evidence base on COVID-19 is rapidly changing. To account for this, published literature will be screened on a weekly basis and monthly evidence updates produced. Updates to the rapid review will be made on a monthly basis, or if the evidence base indicates that a change to recommendations is required.

3.2 Results

An overarching limitation of all identified evidence is the novel nature of SARS-CoV-2 and the limited ability for robust research at the early stages of an outbreak. Most papers highlight the need for further research.

4 Epidemiology

4.1 Transmission routes

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. Preliminary evidence indicates the routes of transmission to be droplet¹⁻¹⁰ and contact.^{1, 3, 6-11} Evidence also supports indirect contact.^{1, 6, 7, 9, 10} These transmission routes are supported by National¹²⁻¹⁴ and international guidance.^{15, 16}

Currently there is no clear evidence of airborne transmission of SARS-CoV-2. Air sampling studies conducted in COVID-19 hospital environments have shown mixed results. A number of international studies (South Korea, Ireland, China, Iran, Italy) returned negative results for the presence of viral RNA by RT-PCR in air samples collected from active air sampling¹⁷⁻²³ or settle plates²⁴ in ICUs, single patient rooms, multi-bed bays, general corridors, fever clinics, ED, treatment rooms and throat swab sampling rooms, and 'clean' areas.²⁵ In these studies, patients were often intubated, mechanically ventilated, on non-invasive ventilation or receiving high-flow nasal oxygen (HFNO). The distance between the air samplers and the patients varied from 0.6m to 5m. Symptom severity, number of days since symptom onset, and ventilation provision in these studies also varied.

Studies that have reported positive air samples are also heterogeneous in terms of patient symptoms, duration since symptom-onset, ventilation provision, and distance of sampler placement from patients. Positive air samples have been reported in isolation rooms and corridors of COVID-designated hospitals,²⁶ airborne isolation rooms of general wards,²⁷ PPE-removal rooms,²⁸ ICUs,^{25, 29, 30} hospital corridors,²⁵ bays,³¹ and single patient rooms.³¹⁻³³ Active air sampling in 2 Wuhan hospitals demonstrated positive results in PPE-removal rooms, which led the author to suggest resuspension of virus-laden aerosols from the surface of contaminated PPE was contributing to air contamination; very low/non-detectable concentrations of viral RNA was detected in COVID-19 ICUs.²⁸ Active air sampling in an ICU treating 15 patients with severe disease and in a general ward treating 24 patients with mild disease returned positive results in 35% of samples collected from the ICU and 12.5% of samples from the general ward.²⁹ A study at a hospital in China detected viral RNA in one out of 12 bedside air samples collected at a distance of 0.2 metres; breath condensate samples from the patient were also positive however it is not possible to distinguish droplet from airborne detection in this study, and there was no data provided regarding the clinical procedures conducted in the room before or during sampling.³⁴ Active air sampling in a London hospital detected viral RNA in samples from multiple patient areas however repeat sampling returned positive results in 3 areas only.³⁵ When testing was carried out in the presence of tracheostomies, only 1 of 8 samples was positive. One out of 12 active air samples taken from COVID-19 patient rooms in a hospital in Wuhan tested positive within 10cm of a patient undergoing endotracheal intubation for invasive mechanical ventilation.³² Four out of 55 samples taken <1m from patients at 8 hospitals in England tested positive; 3 of the 4 patients were undergoing AGPs at the time (CPAP, non-invasive ventilation).³¹

Notably, there is large heterogeneity in the sampling method employed in these studies, and no recognised standard for air sampling, which may impact the observed outcomes. The ventilation systems and modifications also differed significantly between settings. A major limitation in these studies is the lack of detail regarding the types, timing and duration of clinical procedures carried out, therefore limiting a full understanding of their potential impact on the observed sampling results. Positive air samples from ICUs/patient rooms may be a reflection of the higher aerosol risk that is related to aerosol-generating procedures (AGPs) that are conducted in these high risk clinical settings.

Few studies have tested viability of air samples. Four out of 6 samples taken from a single hospital room containing 2 COVID-19 patients at a hospital in Florida were positive; inoculation in Vero E6 cells showed cytopathic effect, suggesting viability.³⁶ Again, this study does not detail the types of patient care activities performed in these rooms. Most studies have been unable to identify viable virus or viral replication in air samples collected from hospital inpatient rooms.^{31, 33, 35, 37, 38}

Aerosol-generating procedures have been associated with an increased risk of transmission of previous coronaviruses (SARS-CoV and MERS-CoV)^{16, 39} and a number of AGPs (mostly airway management) have been implicated as risk factors for transmission of SARS-CoV-2 to health and care workers (HCWs)^{9, 40} however attributing risk to specific procedures with any level of certainty is challenging. The concept of an 'aerosol generating procedure' arose following the study of SARS-CoV transmission events where it was observed that a pathogen, which was consistently associated with droplet or contact transmission, appeared to have the potential to infect HCWs via the airborne route during specific procedures. This is reflected in the World Health Organisation's (WHO) definition of an AGP which states that AGPs create the potential for airborne transmission of infections that may otherwise only be transmissible by the droplet route.⁴¹ It should also be recognised that as well as producing aerosols, these procedures produce larger droplet particles.⁴²⁻⁴⁴

The WHO further defines an AGP as those procedures which result in the production of airborne particles (aerosols).⁴¹ Particles which they describe as being <5 micrometres (µm) in size and as such can remain suspended in the air, travel over a distance and may cause infection if inhaled.⁴¹ These particles are created by air currents moving over the surface of a film of liquid, the faster the air, the smaller the particles produced.⁴¹ Using this definition there are potentially many medical or patient care procedures which could be classed as 'aerosol generating' but whether they lead to an increased risk of respiratory infection transmission is a different and important question. The 2014 WHO guidance is specific in its wording, outlining that '*some procedures potentially capable of generating aerosols are associated with increased risk of SARS transmission to health-care workers*' and they outline that, regarding pandemic and epidemic prone acute respiratory infections, it is for these procedures that airborne precautions should be used.⁴¹ Medical and patient care procedures should be assessed based not only on their capacity to generate aerosols but also on their ability to generate infectious aerosols and an association with relevant transmission events. Health Protection Scotland conducted a review of the evidence base for a number of clinical procedures for their consideration as AGPs in relation to increased risk of respiratory infection transmission, in collaboration with the Department of Health

and Social Care's New and Emerging Respiratory Virus Threat Assessment Group (NERVTAG).⁴⁵ Additional clarity was provided regarding dental procedures and surgical/post-mortem procedures; risk during dentistry is related to the use of high speed devices such as ultrasonic scalers and high speed drills. In surgery/post-mortem, risk is related to the use of high speed cutting if this involves the respiratory tract or paranasal tissues.

4.2 Clinical presentation

Whilst it is apparent that there is variation in the severity and range of symptoms experienced, the most frequently reported symptoms from case and cohort studies include fever and cough.⁴⁶⁻⁵⁹ Initial UK data also reflects this.⁶⁰ Analysis of a large UK cohort of cases hospitalised between 6th February and 8th May (n=24,477) demonstrated that cough was the most prevalent symptom, followed by fever and dyspnoea.⁶¹ Prevalence of individual symptoms varied with age, with fever being less marked at the extremes of age, and runny nose limited to mostly those aged <20 years, especially to those aged under 10 years. A core symptom set of fever, cough, and dyspnoea was identified, and accounted for the largest number of patients (n=9363, 36.%). This core symptom set was found to co-occur with additional symptoms in three patterns; 1) fatigue and confusion, 2) diarrhoea and vomiting, and 3) productive cough. Similar symptom patterns were observed in 4,445 patients from a study of self-reported symptoms of mild disease.⁶¹ Anosmia and ageusia (loss of smell and taste), although more subjective, have also been reported⁶²⁻⁶⁶ and these symptoms were added to the UK's official list of symptoms in May. Amongst hospitalised paediatric and adolescent cases, the most frequently reported symptoms are also fever and cough.⁶⁷ This also appears to be the case in community cases, with runny nose also predominant, however the data is less reliable, being self-reported or reported by a family member.⁶⁸ Paediatric cases tend to have less severe disease, are hospitalised less frequently than adult patients and are less likely to be admitted to ICU.⁶⁹⁻⁷⁵ Analysis of symptoms in 126 residents from 4 care homes in London found that early onset anorexia had the strongest independent association with a positive RT-PCR test; cough or shortness of breath were also significantly and independently associated, whilst fever, altered mental state, and diarrhoea were not.⁷⁶

It is widely recognised that those individuals with underlying comorbidities (diabetes, cardiovascular disease, lung disease, cancer) have an increased risk of ICU admission and mortality.⁷⁷⁻⁸¹ Analysis of 36,398 COVID-19 patients demonstrated that 42.5% had one or more pre-existing morbidity; the most common was hypertension (36.4%), cardiovascular disease (11.9%), and diabetes (22.0%) – mortality rate in the cohort was 14.5% (5,310/36,398).⁸⁰ Higher risk of death was associated with cardiovascular system diseases, immune and metabolic disorders, respiratory diseases, cerebrovascular system diseases, any types of cancer, renal and liver system diseases. Data from a UK cohort has shown that cardiovascular and cerebrovascular disease was significantly more common in patients that had died by 14 days (90% vs 48% in those still alive) and of these congestive cardiac failure was the most notably associated with non-survival (35% vs 11%).⁶⁰ Median age in this study was 75 years. Case fatality was 21%; the authors state this was much higher than that reported by other studies of all hospitalised patients; the age of the cohort was also higher. This was also the case at a South West London hospital in which case fatality was 32.6% in a 500 patient cohort; average age was

69 years (SD 19.23, range 1 week to 88 years).⁸² It is widely recognised that older age groups have higher rates of underlying comorbidities and both have a correlation with a higher risk of COVID-19 mortality. Among paediatric cases, those with underlying comorbidities are significantly more likely to require hospitalisation and ICU admission and have a higher mortality rate.^{75, 83}

Analysis of 53,000 confirmed cases found that 7.7% experienced gastrointestinal symptoms, with approximately 5.7% experiencing diarrhoea.⁸⁴ The incidence of diarrhoea is more variable in smaller cohort studies (2-50%).^{48, 50, 53, 60, 72, 79, 85-92} Nausea and vomiting are also infrequently reported (5.0% of 1099 confirmed cases from Mainland China).^{92, 93} The prevalence of diarrhoea/vomiting in addition to typical symptoms (fever, cough, dyspnoea) was estimated at 5.2% in a large UK cohort of hospitalised cases (n=25,477).⁶¹ Patients reporting with gastrointestinal symptoms were more commonly female, had a longer duration of symptoms before presentation, and had lower 30-day mortality. A number of early papers cited the need for more research into the possibility of faecal-oral transmission^{2, 6, 7, 9-11, 94, 95} following the discovery of viral RNA in the stool samples of COVID-19 patients.^{73, 96-101} Early studies reported on single patient cases^{96, 97, 99, 102} and/or lacked robust clinical data^{96, 98, 103} (i.e. time course of illness, incubation period) which limited interpretation of the epidemiological significance of clinical samples. Pooled detection rates of viral RNA in stool samples have been similar; 43.7% (191/436 cases),¹⁰⁴ 43% (934/2149),¹⁰⁵ and 46.5% (312/671).¹⁰⁶ Evidence has shown that viral RNA can be detected in stool in both children and adults after clearance in respiratory samples,^{88, 92, 105, 107, 108} in the absence of positive respiratory samples,¹⁰⁹ and following resolution of symptoms.^{100, 101, 108, 110, 111} The duration of PCR positivity of stool samples appears to be significantly longer than that of respiratory samples; median 19 days vs. 14 days respectively (p<0.001).¹¹² It is possible that the presence of viral RNA in stool is due to clearance from the mouth/throat into the gastrointestinal tract from swallowing. The transmission risk from non-respiratory samples is still being investigated. Initial attempts at live virus isolation from stool were unsuccessful,¹¹³ however live virus has since been isolated from a stool sample taken approximately 19 days after symptom onset from a severe COVID-19 patient (who subsequently died) in China.¹¹⁴ Following inoculation of Vero E6 cells, a cytopathic effect was observed after two days, and viral particles with the typical morphology of the SARS-CoV-2 virus was observed. Live virus has also been isolated from 62 stool samples collected from 23 patients using Vero cells; medium duration of shedding was 8 days post symptom onset and the probability of detecting isolated virus dropped below 5% after 15.2 days post symptom onset (95% confidence interval (CI) 13.4 – 17.2).¹¹⁵ The sample size in this preprint study was very small and further prospective studies that assess time course of viral shedding in stool in relation to illness progression in individual cases is required. Wolfel et al, in the absence of histopathology, analysed the presence of viral sgRNA in clinical samples, which is only transcribed in infected cells and therefore can indicate the presence of actively-infected cells.¹¹³ They reported 'no or only minimal' indication of replication in stool by this method however this was a small study (n=9) and an area of research that requires further work. Limited data from endoscopic examination of infected patients has revealed positive staining of viral host receptor ACE2 in gastrointestinal epithelial cells, leading to the suggestion that gastrointestinal cells are actively infected¹⁰¹ however this is a single study and an area of research that requires further investigation. To date there is no evidence of direct human-to-human transmission from faecal material.

It is worth noting that the application of standard infection control precautions (SICPs) would prevent ongoing transmission via the faecal-oral route.

Viral RNA has also been detected in blood samples from infected patients.^{98, 116-120} However transmission risk via the blood would be expected to be very low and transmission via this route has not been previously reported for respiratory viruses.

A small cohort study describes identification of viral RNA in vaginal swabs in 2/35 women tested, however repeat testing was not conducted and there is the possibility of contamination from the perineum.¹²¹ A smaller cohort study (n=10) failed to detect any viral RNA in vaginal fluid.¹²² Viral RNA has not been detected in testicular biopsy samples¹²³ or expressed prostatic secretion¹²⁴ in the small number of those tested although has been detected in semen both during infection and after symptom resolution.¹²⁵ Semen samples from 34 Chinese males taken 1 month after COVID-19 diagnosis were all negative,¹²⁶ as was a sample taken 8 days post symptom onset from a single case with mild infection.⁶⁴ Semen samples from a cohort of 20 German males including 2 with active infection and 18 in the convalescent phase (8-54 days after absence of symptoms) all tested negative.¹²⁷ Samples from 6 males collected 1-3 weeks post symptom onset tested negative in the presence of positive saliva and nasal swabs.¹²⁸ Urine samples have tested positive in a small number of cases.^{118-120, 129-131} From a meta-analysis of case series and cohorts with a sample size of ≥ 9 , the estimated viral shedding frequency in urine was 1.18% (CI 95%:0.14 – 2.87).¹³² Viral load in urine was low but detectable and cytopathic effects were observed 3 days after inoculation onto Vero E6 cells¹²⁹ but in a separate study, inoculation onto CaCo-2 cells did not yield results.¹²⁰ These findings do not indicate infection of the kidneys or bladder however they do question the possibility of transmission via the urine.

Peritoneal fluid collected during emergency appendicectomy tested negative for viral RNA.¹³³

SARS-CoV-2 has been detected in the tears and conjunctival secretions in COVID-19 patients with conjunctivitis^{4, 134-139} and without,¹³⁷⁻¹⁴³ leading to the suggestion that transmission could be possible via the mucous membranes and secretions of the eyes.^{144, 145} As sampling of the eyes is not routinely carried out, the overall proportion of cases that have positive eye secretions is unknown. There is no clear evidence of ocular transmission; further information regarding ocular transmission has been covered in the [eye protection rapid review](#). All secretions (except sweat) and excretions from patients with known or suspected COVID-19, should be regarded as potentially infectious.

There is limited evidence regarding mother-to-child transmission. The majority of studies describe development of COVID-19 in the third trimester with subsequent caesarean deliveries and no evidence of vertical transmission.¹⁴⁶⁻¹⁵⁷ There is less evidence for vaginal births but the majority have reported no evidence of vertical transmission.^{154, 156, 158-167} Seven rapid systematic reviews found no clear evidence of vertical transmission,^{161, 168-173} however a systematic review reported a pooled rate of 3.2% (95% CI; 2.2-4.3%) for possible vertical transmission (27/936 neonates tested positive via RT-PCR within 48 hrs of birth).¹⁷⁴ Seven neonates have tested positive by RT-PCT within 24 hrs of birth (1 caesarean, 6 vaginal) with additional positive obstetric tissue samples (amniotic fluid, placenta, umbilical stump); three neonates developed fever at birth, four remained

asymptomatic.¹⁷⁵⁻¹⁸⁰ The mother of one of the neonates was symptomatic at delivery but tested negative by RT-PCR, showing positive serology 10 days later.¹⁷⁷ Twenty-one reports describe positive neonatal samples in 34 neonates within 36 hrs of birth but obstetric samples were either not collected/tested¹⁸¹⁻¹⁹⁷ or tested negative.^{147, 198-200} In these studies, the majority of neonates (25/32; 2 unreported) were delivered by caesarean section; seventeen mothers had mild infection, 2 severe, and 13 unreported, and all were in the late 2nd or 3rd trimester, bar one who was preterm (29 weeks). A single neonate born at 34 weeks via caesarean section tested positive at 49 hrs of life with positive cord blood and urine but remained asymptomatic.²⁰¹ Placental/membrane samples have also tested positive and displayed positive histopathology but in the absence of positive neonatal RT-PCR results.^{163, 202} Antibody testing conducted in neonates has demonstrated mixed results; positive IgM and IgG tests in a number of cases,²⁰³ however in one neonate born to a mother with severe infection, both neonatal IgM and IgG tests were negative.¹⁸² Amongst a cohort of 11 infants born to mothers with COVID-19, all had detectable IgG (100%) and 5 (45.5%) had detectable IgM at birth; RT-PCR test results were all negative.²⁰⁴ The majority of studies which have tested obstetric samples have not been able to detect viral RNA in amniotic fluid, cord blood, placenta, or breast milk in those tested.^{159, 160, 168, 169, 171, 205-207} A small number of cases have reported positive breast milk. RT-PCR testing from a sample taken 1 day after delivery was positive however repeat sampling 2 days later was negative.²⁰⁸ In a separate case, samples taken 10 days post birth were positive but subsequent tests on days 14-25 were negative.²⁰⁹ A third case describes positive viral samples from breast milk of an asymptomatic mother, ingested by a neonate that became SARS-CoV-2 positive at 9h hrs post-vaginal delivery, however alternative transmission routes could not be ruled out.²¹⁰ Transmission events from breast milk to neonate have not been demonstrated to date.²¹¹ The WHO recommend that mothers with suspected or confirmed COVID-19 should be encouraged to initiate or continue to breastfeed.²¹² One neonate delivered vaginally in Italy developed symptoms and tested positive 3 days after birth but it is not clear if the baby was isolated from the mother after birth.²¹³ Whilst many studies describe IPC and isolation measures put in place during and following birth, it is possible that COVID-19 may have been transmitted to neonates from routes other than vertical; immediate testing on delivery may provide more clarity. Overall, evidence suggests very low risk of vertical transmission.

4.3 Atypical presentations

Atypical presentations include cases that do not display the typical clinical symptoms (fever, cough) (which constituted the case definition to date) but may test positive or show radiographic abnormalities (i.e. ground-glass opacity). The absence of respiratory symptoms/fever has frequently been reported in neonates/children^{56, 69, 74, 116, 214-217} and less so in adults^{49, 89, 218}, with diagnosis often relying on RT-PCR and radiological investigation. From analysis of UK cases (n=24,477), those presenting with confusion in the absence of any other symptoms tended to be older (82 years, IQR 75-88).⁶¹ The association between advanced age and confusion was mirrored by a higher prevalence of dementia in these groups. Conjunctivitis in the absence of any other symptoms has also been reported.^{136, 219} An atypical presentation occurred in an Italian national evacuated from China and quarantined on arrival with 56 others as a precautionary measure.¹⁰² This case was a healthy 28 year old male who had no respiratory symptoms but had mild

conjunctivitis and slight tonsillar exudate in the presence of positive naso- and oropharyngeal samples and stool samples. The risk of transmission from these individuals, and whether it differs from that of individuals with typical presentations, has not been determined.

A rare Kawasaki-like disease has been identified in a small number of children presenting with COVID-19 in multiple countries.²²⁰⁻²²² Presence of body and acral rashes with or without additional symptoms has been reported.²²³ Hormati et al provide a brief report on the admission of two patients to a gastroenterology clinic in Iran with unusual gastrointestinal symptoms; both tested positive for COVID-19 in the absence of respiratory symptoms or fever.²²⁴ Again, no transmission events were reported from these patients. A case report describes possible transmission from a 94 year old patient with atypical presentation (delirium, abdominal pain).²²⁵ Nine HCWs and another inpatient developed COVID-19 after the patient was treated in three wards over 5 days with no infection control precautions, highlighting that there is risk of transmission from atypical presentations where no precautions are taken. From UK data, identification of four symptom patterns (gastro-intestinal symptoms, productive cough, confusion, and pauci-symptomatic presentations) were identified as usefully distinct in terms of clinical utility for identifying atypical presentations.⁶¹ Based on the increasing number of reports of atypical presentation, it may be pragmatic to consider widening the case definition as more evidence arises.

4.4 Asymptomatic transmission

A study by Ma et al (*not peer-reviewed*) that assessed clinical symptoms reported by 7 countries, calculated that, among RT-PCR-positive cases with relevant information (n=329), 49 (15%) were asymptomatic however it was not stated if radiographic symptoms were present.⁴⁷ Studies have also reported positive asymptomatic cases, identified during contact tracing, that remained asymptomatic up until the point of negative RT-PCR conversion²²⁶⁻²²⁸ or for the duration of a specified follow-up period.²²⁹⁻²³¹ Universal screening of 52 asymptomatic obstetric patients in Japan identified low prevalence of infection in the cohort (3.8%); all cases remained asymptomatic.²³² A systematic literature review reported an asymptomatic-positive prevalence of 20% (95% CI, 17%-25%, n=6,832) with individuals remaining asymptomatic throughout the course of infection.²³³ Data suggested that the risk of transmission from asymptomatic individuals may be lower than that of symptomatic individuals, however further research is required. Risk of bias from these studies was high, in part due to selection bias. To date, there has been limited evidence of transmission from positive-asymptomatic cases. Contact tracing of a Chinese cohort identified 8 clusters with evidence of asymptomatic transmission from 11 asymptomatic infectees.²³⁰ A number of studies report on identification of viral RNA in clinical samples in asymptomatic patients,^{110, 116, 229, 234-237} and contact tracing has identified possible transmission from a small number of these cases.^{63, 231, 236} Contact tracing identified a possible asymptomatic index case in a family cluster in China²³⁶ and in Vietnam;⁶³ both cases had normal CT imaging and no symptoms. Possible asymptomatic transmission was documented on a flight from Italy to South Korea. All passengers were quarantined on arrival at a government facility for 14 days; 6 passengers tested asymptomatic-positive on the first day of quarantine; one passenger developed symptoms on day 8 of quarantine and tested positive, likely having acquired infection from one of the

asymptomatic-positive passengers.²³¹ It would appear that asymptomatic cases appear to be younger.²³⁸ A growing number of paediatric cases have been reported detailing asymptomatic presentations with positive clinical samples however transmission events from these cases could not be proven.^{56, 68, 70, 74, 110, 116, 227, 234, 239-241} Assessment of a Korean cohort (n=91) of children <19 yrs old found that 42% were asymptomatic at the time of PCR diagnosis and remained so at follow-up.²⁴² The proportions of asymptomatic-positive cases are difficult to contextualise due to a lack of point-prevalence-type data from asymptomatic individuals in the wider community. Data from asymptomatic testing of HCWs has revealed a small proportion to be asymptomatic-positive however transmission events from these individuals was not reported. A point prevalence study of US HCWs at a single centre in New York identified 4.1% (4/98) to be asymptomatic-positive at testing, 2 remained asymptomatic at follow-up.²⁴³ A point prevalence study of UK HCWs undertaken in April found that 2.4% (13/545) were asymptomatic-positive at testing and 8 remained so at follow-up.²⁴⁴ A smaller UK study that routinely tested a cohort of asymptomatic HCWs on a weekly basis identified 44/400 (11%) that tested positive in the absence of symptoms in the week before or after positivity.²⁴⁵ Results from the study suggest a likely reflection of general community transmission, however it does raise concern about the risk of transmission from these individuals. Asymptomatic-positive residents have been identified during universal outbreak screening at long term nursing facilities in the US.^{246, 247} Up to 10.3% (13/126) were asymptomatic-positive during an outbreak and remained so over a 30 day follow up, but symptom history pre-testing was not obtained.²⁴⁶ It is essential that follow-up is undertaken to determine if cases remained asymptomatic-positive or were actually pre-symptomatic, and whether any transmission events from these individuals occurred.

4.5 Pre-symptomatic transmission

Possible transmission in the incubation period has been reported in a number of studies, mainly small cluster case reports.^{235, 248-258} A recent report detailed possible pre-symptomatic transmission in 7 community case clusters in Singapore; date of exposure could be determined in 4 clusters which suggested transmission occurring 1-3 days prior to symptom onset from source patients.²⁴⁹ Analysis of 72 infector-infectee pairs in South Korea estimated transmission onset to have occurred 0.72 days prior to symptom onset; pre-symptomatic transmission was estimated to be applicable to 37% of cases.²⁵⁶ Data from a large Chinese cohort (n=1178) estimated infectiousness to have peaked 1.8 days before symptom onset, with the proportion of pre-symptomatic transmission estimated at 62.5% from 43 transmission events recorded in 23 clusters.²³⁰

Rothe et al report a single case of a Chinese national that travelled to Germany for business and reported hearing coughing from the rows behind on the airplane but was asymptomatic for the duration of contact with German colleagues.²³⁵ Having developed symptoms on return to China, contact tracing was carried out and two German colleagues were identified as positive with mild symptoms. A cluster of cases in Germany developed from this travel-related cluster and a further pre-symptomatic transmission event was identified between 2 individuals that met in a work canteen; this transmission event was strongly supported by virus sequence analysis.²⁵³

Contact during the incubation period during a conference was identified as a possible mode of transmission from a single person to 2 family clusters in China; symptoms in the index case developed 2 days after the conference.²⁵⁰ Transmission in a cluster of young people (16-23 yr olds) in China was linked to an asymptomatic index case who had contact with all persons in the cluster; all cases including the index case subsequently developed symptoms.²⁵¹ The estimated incubation period was notably short (median 2 days) in this study. Two further cases of pre-symptomatic transmission were implicated in familial clusters in China; both cases had contact with a pre-symptomatic individual from Wuhan.²⁵⁰ Contract tracing studies from China have also describe possible pre-symptomatic transmission in the incubation period in clusters of community cases.^{252, 259} As with the aforementioned studies, there were no severe or critical patients in this cohort.

It is notably that these studies did not have clinical data available in the incubation period and relied on contact tracing analysis and retrospective data collection, which is prone to recall bias. There is also the possibility of unidentified infectors in these studies. As clinical sampling may not be widely conducted on mild/community-based cases (or asymptomatic individuals), there may continue to be a paucity of data in relation to determination of asymptomatic/pre-symptomatic transmission. The majority of evidence to date continues to point towards transmission occurring predominantly during the symptomatic period.

4.6 Nosocomial transmission

Data regarding symptoms in HCWs confirms a mirroring of symptoms experienced by the community/general population.²⁶⁰ In a Dutch cohort of 86 COVID-19-positive HCWs, the majority suffered relatively mild disease and 93% met a case definition of fever and/or coughing and/or shortness of breath.²⁶¹ Other symptoms included headache, runny nose, sore throat, chest pain, and diarrhoea. A large proportion (63%) of those screened worked whilst being symptomatic, therefore the possibility of HCW-HCW and HCW-patient transmission (or indeed community transmission) cannot be ruled out, especially considering only 3% reported exposure to a positive inpatient.

There are reports of clear nosocomial transmission during the earlier stages of the epidemic both in the UK and abroad.²⁶²⁻²⁶⁴ In Glasgow, nosocomial infection was documented in patients admitted to medicine for the elderly wards across three hospital sites; 103 patients tested positive after 14 days of admission.²⁶⁴ Mean age of the cohort was 82 years however the infections were recorded prior to the roll out of the Scottish over 70's testing policy (with repeat testing every 4 days during admission) on 29th April; had this been in place, infections would very likely have been identified earlier, as atypical presentation and dementia were challenges for diagnosis in this cohort. Reports from a South West London hospital revealed that 51 of 500 analysed admissions developed COVID-19 nosocomially while inpatients.⁸² A separate inpatient cohort (n=435) from a London teaching hospital reported that 47 cases over a 6 week period met the definition for definite hospital acquisition (symptom onset 14 days or more after admission); many of these cases were identified as having been in the same bay or ward as a patient with PCR-confirmed COVID-19.²⁶⁵ Analysis of cases admitted between 1st March and 19th April at a south-east London teaching hospital revealed that 7.1% (58 cases) were classed as

hospital-associated; median time from admission to symptom onset ranged was 32.5 days (IQR 21-65).²⁶⁶ Nosocomial transmission from an unknown individual to a patient in an ITU, with subsequent transmission to 5 patients and 16 HCWs within the ward, occurred at a tertiary care university hospital in the UK. The infection cluster occurred after hospital visits were stopped and at the same time as lockdown was announced.²⁶⁷ A lack of social distancing between staff may have contributed to transmission, as the working environment did not allow it; unfortunately WGS was not carried out in this study therefore it was not possible to analyse the transmission events with greater clarity. A COVID-19 outbreak on the paediatric dialysis unit of a German hospital involved transmission from an index patient to 7 HCWs and 3 patients.²⁶⁸ Transmission from an undiagnosed neurosurgery patient to 12 HCWs occurred at a hospital in Wuhan; appropriate PPE was not worn, with many HCWs not wearing surgical masks.²⁶⁹ Possible transmission from an undiagnosed patient to 3 HCWs was suspected to have occurred when performing a bronchoscopy ('procedure' masks were worn, not respirators), however genetic sequencing was not carried out and contact tracing is not described in detail.²⁷⁰ A case report describes possible transmission from a 94 year old patient with atypical presentation (delirium, abdominal pain) to 9 HCWs and another inpatient after the patient was treated in three wards over 5 days with no infection control precautions.²²⁵ The differing case definitions used by various studies to define a hospital-associated COVID-19 make direct comparisons challenging.

Research conducted in March/April with NHS England Trusts to inform the Scientific Advisory Group for Emergencies (SAGE) suggested that nosocomial transmission of COVID-19 was occurring during that time, with 8.2% of cases being diagnosed 14 days post-admission (inter-quartile range 3.8% to 12.0%). It was reported that few Trusts were assessing the possible involvement of HCWs in transmissions. As sustained community transmission has occurred as the pandemic has progressed, it has become more challenging to identify true nosocomial transmission events particularly in regards to HCW acquisition. In Scotland, during the period 1st March-6th June, HCWs or their households made up 17.2% (360/2097) of all hospital admissions for COVID-19 in the working age population.²⁷¹ Healthcare workers in patient-facing roles were at higher risk of hospital admission (hazard ratio 3.30, 2.13-5.13) than non-patient-facing HCWs, as were their household members (1.79, 1.10-2.91).²⁷¹ Most patient facing healthcare workers were in "front door" roles (e.g. paramedics, acute receiving specialties, intensive care, respiratory medicine). Those in non-patient-facing roles had a similar risk of hospital admission as the general population. This was not the case in an English cohort; screening of 1654 symptomatic HCWs by an English NHS Trust between March 10-31st identified 240 (14%) positive individuals; comparison of rates between staff in patient-facing and non-patient facing roles found no evidence of a difference, suggesting that data may reflect wider patterns of community transmission rather than nosocomial-only transmission.²⁷² Mirroring of community transmission was also identified at a large public hospital in Madrid,²⁷³ and at three hospitals in the Netherlands; contacts with COVID-19 individuals was reported from out-with the hospital and from contact with colleagues.²⁷⁴ Complete genome sequencing of 50 HCW and 18 patients suggested that the observed patterns were most consistent with multiple introductions into the hospital.²⁷⁴ Genetic sequencing provided confirmatory evidence for community transmission to a HCW, ruling out suspected transmission from two COVID-19 patients.²⁷⁵ Whole genome sequencing was used as

part of outbreak investigations at a hospital in Ireland and revealed that HCWs moving between wards were responsible for transmission to patients and other HCWs.²⁷⁶

Whilst transmission from asymptomatic HCWs has not been documented, a UK study identified a small proportion (0.5% of 1,032) of asymptomatic-positive HCWs during a routine screening study, highlighting the risk of transmission from these individuals.²⁷⁷ HCWs working in 'red' or 'amber' wards were significantly more likely to test positive than those working in 'green' wards ($p=0.0042$) – this was the case for both symptomatic and asymptomatic-positive HCWs. Contact tracing at a hospital in the US that involved testing of asymptomatic HCWs revealed a number of exposures between staff to have occurred when the index HCW case was pre-symptomatic.²⁷⁸ Interestingly, none of the confirmed HCW cases occurred in staff working on COVID-19 designated wards. Data from 4 London care homes identified 44 residents (17% of the 264 cohort) that were asymptomatic-positive and remained so at follow-up.⁷⁶ Further, 7.9% were pre-symptomatic.²⁷⁹ Some SARS-CoV-2 sequence variants were highly similar between residents and/or staff within a single care home; there were also multiple distinct clusters of SARS-CoV-2 sequence types within single nursing homes, suggestive of multiple introductions.⁷⁶ Analysis of 24 Irish care homes found the median proportion of asymptomatic-positive staff was 19.6% (IQR 11.8-52.3%); asymptomatic was defined as without symptoms 7-days either side of a test.²⁸⁰ Over 25% of residents with lab-confirmed infection were asymptomatic. It was not possible to determine the impact of these individuals on transmission in these settings.

It is notable that not all unprotected exposures to COVID-19-positive individuals result in transmission; none of the 21 HCWs that reported contact with an undiagnosed patient with mild respiratory symptoms at a Swiss hospital tested positive when tested 7 days later.²⁸¹ The patient underwent routine clinical examinations, blood draws, electrocardiograms, chest X-rays and had nasopharyngeal swabs taken; masks were never worn by HCWs during the patient's care. In Germany, a physician worked over a number of days in a hospital whilst symptomatic (coughing, fever) and with no mask, but did not transmit infection to any of the 254 identified contacts (HCWs and patients).²⁸² In Singapore, 41 HCWs were exposed to multiple AGPs at a distance of less than 2 metres for at least 10 minutes while wearing predominantly surgical masks (only 25% wore N95 respirators) whilst caring for a patient with undiagnosed COVID-19; none of the HCWs developed symptoms or tested positive (with repeat testing) in the 14 days following exposure.²⁸³

Conclusion:

- Standard Infection Control Precautions (SICPs) should always be applied in all situations regardless of the infectious nature of the patient.
- Droplet precautions should be implemented when in close contact (within 2 metres), or providing direct patient care to a suspected/confirmed COVID-19 patient.
- Airborne precautions should be implemented when undertaking an AGP on a suspected/confirmed COVID-19 patient within the medium risk (amber) and high risk (red) pathways.

4.7 Incubation period

Many of the studies published to date are limited by small sample sizes and over-representation of severe cases, the incubation period for which may differ from that of mild cases. Evidence suggests an incubation period of 5-6 days^{7, 10, 57, 79, 91, 253, 257, 260, 284-299} with a range of 1-14 days^{7, 8, 11, 50, 53, 79, 93, 256, 260, 287, 288, 290, 291, 300-303} from infection to symptoms surfacing. Further analysis of 2,555 Chinese community cases indicates a longer incubation period of 9 days.³⁰⁴ Lauer et al estimate that most (97%) of those who develop symptoms do so within 11.5 days of infection (95% CI, 8.2-15.6).²⁸⁶ Analysis of a Chinese cohort (n=183) provided an estimate that 95% of those who develop symptoms will do so within 14 days of infection (95% CI; 12.2-15.9).³⁰⁵ Consequently only a limited number of cases will potentially develop symptoms out-with the 14 days of self-isolation that is required following contact with a confirmed case.

Conclusion:

- The incubation period for most individuals is reported as 5-6 days (range 1-14 days).
- Self-isolation for 14 days is recommended for contacts of symptomatic cases.

4.8 Infectious period

In most cases, individuals are usually considered infectious whilst they have respiratory symptoms; how infectious an individual is likely depends on the severity of their symptoms and stage of their illness. Initial data from Wuhan suggested a median time from symptom onset to clinical recovery for mild cases of approximately 2 weeks, and 3-6 weeks for severe or critical cases however this data is likely biased by the fact that the majority of cases included in the study were hospitalized; the proportion of milder community cases is likely underestimated.²⁸⁷

Less is known about the duration of infectivity. From limited international data, the balance of evidence is that, for mild cases of infection, infectivity (as determined by respiratory RT-PCR sampling) peaks at symptom onset and significantly reduces 7 days after the onset of symptoms but appears to take longer for severe cases.^{113, 287, 306-309} Community transmission on the day of symptom onset (when symptoms are mild and non-specific) has been reported but is reliant on retrospective self-reported data.³¹⁰ Analysis of 301 hospitalised cases revealed that the positive rate of RT-PCR assay was highest at day 0-7 (97.9 %) after symptom onset then decreased with time; after 4 weeks, 26.3% of samples were still positive.³¹¹ It was also observed that patients ≥65 years old shed virus for a longer period (22 days vs 19 days, p=0.015).

Prolonged detection of viral RNA up to 28 days (and in some cases longer) after symptom onset has been reported from hospitalised cohorts^{66, 312-315} and from community cohorts. Analysis of a US cohort of 121 patients and HCWs demonstrated an average time of 24 days after symptom onset for transition from RT-PCR positive to negative; 10% remained positive 33 days after symptom onset.³¹⁶ Details of symptoms and infection severity were not reported, however there is evidence that patients with severe infection (requiring ICU admission) shed virus (as detected in nasal swabs) for significantly longer than non-ICU

patients.¹⁴¹ Cohort studies (limited by their small sample sizes) have shown that patients can continue to have viral RNA detected in respiratory and stool samples for more than 14 days.³¹⁷⁻³¹⁹ In an Italian community cohort, viral clearance was achieved by 60.6% (704/1162) of patients, with a median of 30 days from diagnosis (IQR 23-40) and 36 days from symptom onset (IQR 28-45).³²⁰ From a retrospective cohort of 537 symptomatic community cases in Germany (isolating at home), 53.5% remained positive by PCR at 14 days after symptom onset.³²¹ A mean duration of viral RNA detection was estimated at 14.96 days after symptom onset. Hospitalisation before home isolation was associated with a 26% longer duration of PCR positivity compared with patients in home isolation throughout (time ratio: 1.26; $p=0.049$). Details regarding the presence and severity of symptoms throughout the isolation period were not provided. Prolonged viral RNA detection is an issue where discharge/release from isolation is reliant on 2 consecutive negative PCR results. Analysis of a small cohort of cases in Wuhan that returned home after a 14 day isolation period following hospitalisation and were still PCR-positive found no onward transmission to household contacts.³²² None of the household contacts developed any symptoms and both PCR and IgM/IgG antibody testing were negative. Median time of PCR-positivity was 78 days (IQR 67.7-84.5) with the longest duration found to be 120 days. Exhaled breath condensate samples collected ~40 days post-symptom onset from 2 elderly hospitalised patients (medium/severe disease) that met the requirements for discharge (negative PCR throat swab and clinically well) tested positive however these samples were not cultured to test viability.³²³ Repeat testing with a larger sample size would provide a more reliable evidence base regarding exhaled breath condensate sampling.

Prolonged viral shedding may not correlate with infectiousness; there is limited evidence regarding this as the infectious dose required for transmission has yet to be determined. Wolfel et al assessed 9 cases in Munich, Germany and found that live virus could be isolated from respiratory samples taken within the first 7 days of symptoms but not from day 8 onwards, *even though viral RNA could still be detected in samples*.¹¹³ Live virus isolation may also be dependent on viral load; samples containing under 10^6 copies/mL (or copies per sample) never yielded an isolate.¹¹³ In the absence of histopathology, the same study analysed the presence of viral sgRNA which is only transcribed in infected cells and therefore can indicate the presence of actively-infected cells in samples. Throat swabs taken up to day 5 were positive while no sgRNA was detected thereafter. This suggests that as viral load reduces in the later stages of infection, so too does transmission risk. Wolfel et al estimate that, for patients beyond day 10 of symptoms and with less than 100,000 viral RNA copies per ml of sputum, early discharge with ensuing home isolation might be appropriate.¹¹³ Analysis of sgRNA in samples from a patient cohort ($n=35$) with mild infection found it was detectable in 18/22 (81.8%) of specimens collected <8 days after symptom onset but only in 1/11 (9.1%) of those collected >9 days after symptom onset ($P=0.0003$).³²⁴ The median viral load in culture-positive samples was significantly higher than in culture-negative samples ($p=0.00001$). Analysis of 754 samples from 425 symptomatic cases in the UK found that levels of viral RNA (determined from the RT-PCR cycle threshold values) in the upper respiratory tract were greatest around symptom onset, steadily decreased during the first 10 days after symptom onset and then plateaued.³²⁵ Detection of culturable virus peaked around the time of symptom onset; median duration of virus shedding as measured by culture was 4 days (IQR 1-8, range -13 to 12). Culture positivity rate was significantly higher during week 1 than week 2

(74% vs 20%, $p=0.002$). Ten days after symptom onset, the probability of culturing virus declined to 6.0% (95% CI: 0.9–31.2%). A Canadian study found there was no growth on viral culture from samples taken >8 days since symptom onset; the probability of obtaining a positive viral culture peaked on day 3 and decreased from that point.³²⁶ Vero cell infectivity was only observed for samples with a cycle threshold value <24. A further study that conducted viral culture of 46 cases reported a mean duration from symptom onset to culture positivity of 4.5 days (range 0-18 days); whilst one patient continued to be culture positive to day 18, no others were positive beyond 10 days after symptom onset.³²⁷ Cultures were significantly more likely to be positive from samples collected within the first week after symptom onset when compared to the second week (80% vs 45%, $p=0.002$), and from samples collected in the second week compared to the third week (45% vs 4%, $p<0.001$). Ten days was also reported as the maximum number of days post-symptom onset that viral culture could be demonstrated in positive samples from outpatients with mild infection; samples from moderate to severe hospitalized cases could be cultured up to 32 days post-symptom onset.³²⁸ Viral culture has also been demonstrated in children during early acute illness.³²⁹ A French study that assessed viral culture ($n=124$ samples) in relation to viral load of PCR clinical samples demonstrated a significant correlation between successful isolation of virus in cell culture and Ct values of 13-17.³³⁰ Culture positive rate then decreased progressively according to Ct values to reach 12% at 33 Ct; no culture was obtained from samples with Ct>34. These findings are similar to those from a hospitalised Singapore cohort ($n=100$, 20% required supplemental oxygen) where no virus was able to be isolated when the Ct value was >30, or when patients were >14 days post symptom onset.³³¹ The authors propose that each centre should perform its own correlation study to aid with determination of infectivity cut-off, which may be used to assist decision making regarding hospital discharge.³³⁰ However, current UK guidance (published 28th October 2020) advises that a single Ct value in the absence of clinical context cannot be relied upon for decision making about a person's infectivity.³³² In summary, the evidence base suggests that culture-positive samples tend to have higher viral loads than culture-negative samples, culture positivity peaks close to symptom onset, and culture positivity significantly decreases ~10 days post symptom onset. Further research is required in the area of viral isolation and cycle threshold analysis to develop a robust evidence base to assist with discharge decision-making.

Data from a number of studies has demonstrated a pattern with viral clearance with regards to clinical sample type; viral presence in respiratory samples appears to peak in the earlier stages of infection then decreases with time whilst the opposite has been observed with stool samples.^{100, 101, 110, 119, 319} Analysis of hospitalized cases in China indicated an association between hypertension and delayed viral clearance.^{307, 333} Hypertension is the most frequently reported CV comorbidity associated with COVID-19 infection; hypertensive patients also have a higher mortality rate compared to normotensive patients.⁷⁷ This has led to the suggestion that treatment with ACE2 inhibitors (antihypertensive medication) in patients with hypertension might facilitate SARS-CoV-2 to enter the targeted cells via ACE2 receptors in the respiratory system, and thus prolong the time of viral clearance.³⁰⁷ Further research is required to detangle the association between severe disease, comorbidities, and delayed viral clearance.

Reports that suggest possible infectivity in the asymptomatic period are based on limited evidence from largely retrospective observations during contact tracing, and identification

of viral RNA in clinical samples post symptom resolution.^{10, 100, 116, 234, 235, 300, 334-336}

Concerns over risk of transmission in the incubation period have been raised following identification of possible transmission events in the incubation period from contact tracing studies, and observations of positive clinical samples prior to symptom onset. A report from a long term care facility in which two rounds of 'point prevalence' COVID-19 screening were carried out (1 week apart), found that more than half the residents (27 of 48) who had positive tests were asymptomatic at testing.³³⁷ Further, 17 of 24 specimens (71%) from pre-symptomatic persons (those who were asymptomatic at testing but went on to develop disease) had viable virus by culture 1 to 6 days before the development of symptoms. Possible transmission events from these individuals were not reported. Identification of RT-PCR positivity in the incubation period has also been reported in South Korea; 41 out of 213 tested (19.2%) were asymptomatic at testing.³³⁸ Progression to disease was not reported; all individuals were isolated therefore transmission events in this cohort were not assessed. Unfortunately, contact tracing studies frequently lack accompanying clinical data i.e. RT-PCR testing from the incubation period, due to their retrospective nature.

Knowledge is also limited regarding the transmission dynamics of asymptomatic-positive cases. Analysis of the initial RNA load and threshold cycle value ('Ct' value, which is inversely proportional to the viral load) from a number of small studies indicates a lower viral load in asymptomatic cases during hospitalisation.^{119, 237, 268} In one study, symptomatic cases had an approximately 200-fold higher viral load.²⁶⁸ However, a larger study found that the initial threshold cycle value of nasopharyngeal RNA in asymptomatic carriers was similar to that in pre-symptomatic and symptomatic patients, but that viral clearance was faster, as the RNA negative-conversion occurred earlier for asymptomatic cases.²³⁹ From this, the authors deduced that the communicable period of asymptomatic cases was shorter than pre-symptomatic patients (9.63 days vs. 13.6 days). Significantly faster viral clearance in asymptomatic cases has been demonstrated in a number of small studies.^{63, 237} Analysis of 82 Chinese cases found that those with respiratory symptoms (cough) had a statistically significantly longer duration of positive testing by nasopharyngeal swab compared to patients presenting without respiratory symptoms (17 days vs. 13 days, $p = 0.041$).³³⁹

In general, the evidence regarding the transmission dynamics from asymptomatic cases is weak; further research is required.

Guidance from the ECDC recommends that COVID-19 patients may be discharged from hospital based on: a) clinical resolution of symptoms, and b) evidence for viral RNA clearance which would be 2 negative RT-PCR tests from respiratory specimens at 24 hrs interval at least 8 days after onset of symptoms, where testing capacity permits.³⁴⁰

However in light of the widespread community transmission, clinical criteria should gain priority. This is consistent with Scottish and UK guidance which recommends discharge as soon as the patient is clinically well enough (i.e. symptoms may still be present).^{341, 342} Those discharged should self-isolate for 14 days (minimum) from symptom onset (or first positive test if symptoms onset undetermined), with absence of fever for 48 hours without the use of antipyretics.^{341, 342} However, patients being discharged into a care facility (residential or care home) should have 2 negative tests prior to discharge, unless there are overriding clinical reasons where this is not appropriate (patient doesn't consent or it would

cause distress).³⁴¹

Conclusion:

- Transmission is most likely to occur whilst an individual is symptomatic.
- In mild cases of infection, where hospitalisation is not required, the risk of transmission is thought to significantly reduce after 7 days.
- Individuals with symptoms consistent with COVID-19 should self-isolate for 10 days from symptom onset.
- In severe cases the risk of transmission may extend beyond 7 days therefore Transmission Based Precautions (TBPs) should remain in place for the duration of hospital admission or home isolation until cessation of symptoms.
- In hospital settings clinicians should consider extending isolation for some cases e.g. elderly, immunosuppressed, if they remain symptomatic after 14 days until test results are available.
- Patients discharged from hospital should self-isolate for 14 days from symptom onset (or first positive test if symptom onset undetermined) with absence of fever (without use of antipyretics) for 48 hours.

5 Personal protective equipment

There was limited evidence for the assessment of the PPE requirements for the prevention of transmission of SARS-CoV-2. Determination of the PPE requirements for new pathogens is usually based on previous experience with similar pathogens and/or similarly-transmitted pathogens. Determination of the efficacy of PPE recommendations is based on retrospective analyses of possible transmission events to HCWs, where any associations with PPE worn at the time are assessed. Such assessments are considered to be low quality evidence and prone to confounding.

5.1 Surgical face masks

It is vital that a distinction is made between the evidence pertaining to fluid-resistant surgical face masks (FRSM) (Type IIR) and standard (non-fluid-resistant) surgical face masks (Types I & II). Surgical masks are tested against the safety standard BS EN 14683:2019; this series of tests measures the performance of a surgical mask in bacterial filtration efficiency (BFE), breathing resistance and splash resistance. Type II and Type IIR surgical masks are both tested against this standard with them needing to meet a minimum BFE of 98%; however only Type IIR masks must pass the splash resistance test with a resistance of at least 16.0kPa. The terms 'fluid resistant' and 'fluid repellent' are often used interchangeably to denote a Type IIR surgical mask, however, terminology may vary internationally and a 'fluid repellent' mask may occasionally describe a mask that does not meet the BS EN 14683:2019 splash resistance standard and which is not suitable for protection against splash or spray i.e. a Type II surgical mask. In the UK, when

recommended for infection prevention and control purposes a 'surgical mask' will be a fluid-resistant (Type IIR) surgical mask.

Standard surgical face masks (i.e. Type II) can be worn by an infectious individual to prevent transmission.³⁴³⁻³⁴⁵ To demonstrate this, a study by *Leung et al* tested the efficacy of surgical masks at reducing the detection of seasonal (non-COVID-19) coronavirus in exhaled breath from infected patients.³⁴⁶ Coronavirus could be detected in ~40% of samples collected from non-mask wearers (n=10) but was not detected in exhaled air from patients that wore surgical masks (n=11). The masks used were Type II, i.e. they were not fluid-resistant. This study was limited by the small sample size – due in part to the fact that a large proportion of infected participants had undetectable viral shedding in exhaled breath. Studies assessing Type II surgical masks have also reported reduced detection of seasonal influenza in exhaled breath in mask wearers.^{346, 347} An environmental sampling study of multiple sites (prior to environmental cleaning) surrounding 3 hospitalised COVID-19 patients yielded negative results; two of these patients wore surgical masks continually and the critical bed-bound ICU patient had a closed loop circuit ventilator.³⁴⁸ All patients tested positive by throat swab on the day of sampling and the masks and the closed suction tube tested positive.

Whereas standard surgical face masks can be worn by an infectious individual to prevent transmission, it is the fluid-resistant nature of FRSMs that provides additional protection to the wearer (e.g. HCW) against droplet-transmitted infectious agents. Guidance consistently recommends that HCWs should wear a Type IIR FRSM as PPE when caring for a patient known, or suspected, to be infected with an infectious agent spread by the droplet route.^{41, 343, 345, 349-353} In UK health and care settings, surgical masks must be fluid-resistant, 'CE' marked and compliant with Medical Device Directive (MDD/93/42/EEC) and the Personal Protective Equipment Regulations 2002.³⁵⁴⁻³⁵⁹

Surgical masks do not provide protection against airborne particles and are not classified as respiratory protective devices.³⁶⁰ Assessment of PPE use against similar coronaviruses i.e. severe acute respiratory virus (SARS), provides weak evidence that droplet precautions (i.e. surgical masks) are adequate. A systematic review and meta-analysis combining 6 case-control and 3 cohort studies, found that use of respirators/masks provided significant protection against SARS-CoV among exposed HCWs (OR=0.22; 95% CI: 0.12-0.40). Wearing surgical masks (OR=0.13; 95% CI: 0.03-0.62) or N95 respirators (OR=0.12; 95% CI: 0.06-0.26) (versus no RPE) both reduced the risk of SARS-CoV by approximately 80%. No protective effect was reported for disposable cotton or paper masks. The existing evidence base in the review was sparse and the indications (and compliance) for mask/respirator use varied between the included studies.³⁶¹ The type of surgical mask was not reported in all studies. A case control study that compared PPE use in 241 non-infected HCWs and 13 infected HCWs with documented exposure to 11 index patients with SARS-CoV found that none of the infected staff wore surgical masks or respirators (2 wore paper masks).³⁶² However, RT-PCR analysis was not used to confirm infection in this study (confirmation of HCWs relied on serological analysis), and recall bias for PPE use may have affected results. Inadequate reporting of RPE/mask indications and compliance was a major limitation in a recent systematic review and meta-analysis conducted by *Bartoszko et al*, which included 4 RCTs and reported that, compared to N95 respirators, the use of medical masks was not associated with an increase in laboratory-confirmed viral respiratory infection or respiratory

illness.³⁶³ There was significant variation in surgical mask type between the included studies (Type IIR FRSMs were not used in every study). A rapid review conducted specifically to assess the RPE requirements for COVID-19 in primary care determined that the evidence base was weak as the included studies were focussed on influenza transmission, not COVID-19; these studies provided weak support for the use of standard surgical masks in non-AGP settings.³⁶⁴ A recent update to a Cochrane systematic review that assessed full body PPE for the prevention of exposure to highly infectious diseases (including COVID-19) found that covering more parts of the body leads to better protection but usually comes at the cost of more difficult donning or doffing and less user comfort, and may therefore even lead to more contamination.³⁶⁵ Certainty of the evidence was judged as low due to the fact that almost all findings were based on one or at most two small simulation studies. An experimental study using simulated SARS-CoV-2 virus expulsions and mannequin heads demonstrated a synergistic protective effect when both the spreader and receiver wore a mask (cotton or surgical), suggesting that universal face covering/mask wearing is likely to have a protective effect overall.³⁶⁶

For all non-AGP scenarios, there is no clear evidence that respirators offer any additional protection against droplet-spread infectious disease, including coronaviruses.

Guidance issued by the Scottish Government on 23rd June advised that all staff in hospitals and care homes in Scotland are required to wear a 'medical' face mask at all times throughout their shift, from 29th June onwards.³⁶⁷ Patients and visitors to hospitals and care homes must wear a face covering. Staff must also wear a face covering when they are out with clinical areas/not on duty. Face mask/covering requirements were extended to include primary care (GP practices, dentists, opticians and pharmacies) and wider community care (including adult social or community care and adult residential settings, care home settings and domiciliary care) on 18th September.³⁶⁷ The main purpose of these measures is to prevent transmission of the virus from the person wearing the face mask, in recognition of the risk of pre-symptomatic and asymptomatic transmission, and the difficulties in maintaining physical distancing in the workplace.

The new Scottish COVID-19 addendum for acute care settings published within the NIPCM on October 27th 2020 states that HCWs should wear a type IIR fluid resistant surgical mask for all direct contact with patients, and when carrying out AGPs in the green pathway.³⁶⁸ Inpatients in high-risk (red) and medium-risk (amber) pathways must wear a surgical facemask at all times if it can be tolerated and if it does not compromise their clinical care. Patients on the low-risk (green) pathway are not required to wear a surgical facemask. All patients across all pathways must wear a surgical facemask during transfer between departments within the hospital.

Conclusion:

- Health and care workers across all pathways should wear a type IIR fluid-resistant surgical face mask throughout their shift; a type II surgical face mask may be worn by HCWs that are not involved in direct patient care/not at risk of splashing/spraying.

- HCWs should wear a type IIR fluid-resistant surgical face mask during any activities/procedures where there is a risk of blood, body fluids, secretions or excretions splashing or spraying onto their nose or mouth.
- Non-medical staff and HCWs off duty/out-with clinical areas should wear a face covering.
- All patients and visitors entering a healthcare setting should wear a face covering.
- Inpatients within the medium and red pathways in acute care settings should wear either a type II or IIR fluid-resistant surgical mask at all times if they can be tolerated and care is not compromised.

5.2 Face visors

The new Scottish COVID-19 addendum for acute settings (published 27th October 2020) recommends that eye/face protection should be worn at all times during direct contact in high-risk (red) pathways and this is always in combination with a face mask or respirator.³⁶⁸ For low-risk (green) and medium-risk (amber) pathways, eye/face protection is only required if splashing or spraying with blood and/or body fluids is anticipated and again, this is always in combination with a face mask. Whilst the NIPCM Chapter 1 currently states that for SICPs a face visor can be used without a face covering to provide eye/face protection against splash and spray, at no point should a face visor be worn in place of a face mask when providing care on any of the three COVID-19 pathways. There is some evidence from experimental studies to support that face visors alone are less effective than other forms of face protection at preventing influx of exhaled droplets/aerosols; these are covered in more detail in the [eye protection rapid review](#). This is also the case for source control; an experimental study found that a face shield blocked only 2% of experimentally exhaled cough aerosols compared to 59% blocked by a fluid-resistant face mask and 51% blocked by a 3-ply cotton face covering.³⁶⁹

Conclusion:

- Eye/face protection should be worn if splashing or spraying with blood and/or body fluids is anticipated.
- A face visor should not be worn in place of a surgical face mask or respirator.

5.3 Respiratory protective equipment (RPE)

The WHO defines an AGP as a medical or care procedure that creates the potential for airborne transmission of infections that may otherwise only be transmissible by the droplet route.⁴¹ It should also be recognised that as well as producing aerosols, these procedures produce larger droplet particles.⁴²⁻⁴⁴ During AGPs there is an increased risk of aerosol spread of infectious agents irrespective of the mode of transmission (contact, droplet, or airborne) and airborne precautions (FFP3 respirator and facial protection) must be implemented.³⁷⁰

It is important to note that not all FFP3 respirators are fluid-resistant; valved respirators can be shrouded or unshrouded. Respirators with unshrouded valves are not considered to be fluid-resistant and therefore should be worn with a full face shield if blood or body fluid splashing is anticipated. This must be taken into consideration where FFP3 respirators are being used for protection against COVID-19 transmission.

Conclusion:

- Airborne precautions (FFP3 respirators) are required when performing AGPs on patients in the medium risk (amber) and high risk (red) pathways.
- Consideration should be given to the application of airborne precautions where the number of cases of COVID-19 in amber and red pathways requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

5.4 UK PPE guidance

For general patient care (i.e. non-AGP situations), the first edition of the UK IPC pandemic COVID-19 guidance initially recommended type IIR FRSMs, disposable aprons and disposable gloves.¹⁴ The decision to wear eye protection was based on risk assessment (but considered essential when carrying out AGPs). Fluid-resistant long sleeve gowns were recommended for management of confirmed cases and when carrying out AGPs.¹⁴ FFP3 respirators were recommended when carrying out AGPs and when in high risk areas where AGPs are being conducted. The FFP3 recommendation was based on expert opinion from NERVTAG which recommended that airborne precautions should be implemented at all times in clinical areas considered AGP 'hot spots' e.g. Intensive Care Units (ICU), Intensive Therapy Units (ITU) or High Dependency Units (HDU) that are managing COVID-19 patients (unless patients are isolated in a negative pressure isolation room/or single room, where only staff entering the room need wear a FFP3 respirator).

The UK IPC pandemic COVID-19 guidance was updated on 2nd April 2020 with a move to PPE based on risk of exposure to possible (not suspected/confirmed) cases, with recommended ensembles for specific care areas/clinical situations.³⁷¹ The guidance stated that *'incidence of COVID-19 varies across the UK and risk is not uniform and so elements of the updated guidance are intended for interpretation and application dependent on local assessment of risk'*. While this was not in line with the evidence base to date for COVID-19 as presented in this rapid review, it was based on the potential challenges in establishing whether patients and individuals meet the case definition for COVID-19 prior to a face-to-face assessment or care episode. There was also a move towards sessional use of PPE considering the recognised global shortage of PPE stockpiles at the time and perhaps in recognition of the fact that the change in UK PPE recommendations were likely to result in greater use of PPE by a wider staff group which would deplete existing UK stocks.

PPE guidance was most recently updated on 20th August with the publication of IPC guidance for remobilisation of service in health and care settings.³⁷² A major change was the introduction of 3 patient pathways for COVID-19 which set out the PPE requirements for each area. Scottish COVID-19 guidance (in the form of an addendum) was published in the NIPCM on 27th October 2020. There is a return to SICPs-based PPE, with PPE

usage dictated by anticipated blood and/or body fluid exposure, and respirators only required for AGPs on patients in the amber and red pathways.

Additionally, as per interim guidance published by the Scottish Government on June 23rd 2020, surgical face masks must be worn at all times by HCWs in clinical areas across all pathways within acute adult hospitals, community hospitals, and care homes for the elderly, to reduce the risk of source transmission.³⁶⁷ This also applies to patients and visitors, who are required to wear a face covering at all times, and all staff out with clinical areas/not on duty who are also required to wear a face covering. Face mask/covering requirements were extended to include primary care (GP practices, dentists, opticians and pharmacies) and wider community care (including adult social or community care and adult residential settings, care home settings and domiciliary care) on 18th September.³⁶⁷

Reuse of PPE (FFP3/FF2/N95 respirators, fluid-resistant gowns or coveralls, goggles and face visors) as advised for periods of PPE shortages in a previous version of the IPC guidance in April 17th 2020, is no longer recommended.

The safety and efficacy of extended use or re-use of PPE has not been extensively studied. An evidence summary by ECRI (Emergency Care Research Institute), a US company that evaluates medical devices, evaluated 21 laboratory studies and concluded that extended use (i.e. sessional use) of N95 respirators was preferable to reuse.³⁷³ Mechanical failure (e.g. broken straps and poor sealing between the mask and the user's face) following only a few reuses was common across a number of FDA-cleared N95 respirators. The reported pathogen transfer risk from contact during donning and doffing during reuse was considered to be higher than the risk from sessional wear. Use of surgical masks or similar disposable covers over N95s during sessional wear were unlikely to result in significant adverse effects. Reuse would require disinfection however loss of filter performance was reported with some common disinfection methods. The methods for disinfection included humid heat, chemical disinfection, and ultraviolet germicidal irradiation (UVGI). The ECRI report summarises the findings from a number of decontamination studies conducted; steam sterilisation required 10 minutes at a minimum of 121°C to be effective however it may damage polymer fibres in the filter and compromise performance; chemical disinfection was limited by the risk of toxicity and chemical incompatibility with filter materials; UVGI penetration may be incomplete in multi-layered N95 filters, which has been evidenced experimentally.³⁷⁴ UVGI is capable of inactivating coronaviruses including MERS-CoV and SARS-CoV however these tests were not conducted on any type of PPE.³⁷⁵ UV radiation degrades polymers which presents the possibility that UVGI exposure may reduce the efficacy of respirators.³⁷⁶ A previous study demonstrated degradation of 4 different types of N95 respirators at doses of 120-950 J/cm².³⁷⁷ Attempts at using steam sterilisation of FFP respirators has shown promise however rigorous testing in line with EN standards for respirator efficacy is required.³⁷⁸ In a separate study, heat treatment at 70°C at either 0% or 50% humidity did not appear to damage N95 masks nor compromise fit performance, however this study only measured the efficacy of this method at removing SARS-CoV-2 from respirators by using respirator material that had been cut into 1cm² pieces.³⁷⁹ None of the eight different decontamination methods that were tested on different N95 respirator models were suitable, failing in terms of ability to penetrate the filters and/or as a result of damage to the respirators.³⁸⁰ The methods included UVGI, ethylene oxide, hydrogen peroxide gas plasma, hydrogen peroxide vapour, microwave-oven-generated steam, bleach, liquid

hydrogen peroxide, and moist heat incubation (pasteurization). Disinfection using aerosolised peracetic acid and hydrogen peroxide vapour was found to be effective at reducing contamination of a surrogate coronavirus bacteriophage on N95 respirators.³⁸¹ Use of vaporised hydrogen peroxide was also found to be suitable for N95 respirator decontamination using an experimental inoculum of SARS-CoV-2 with a cycle threshold value of 20–22.³⁸² Notably, the safety of these chemicals for this purpose has not been tested and decontamination should be tested on naturally contaminated PPE, as experimental contamination may not be representative of the levels of contamination experienced in real-life clinical scenarios.

UK IPC pandemic COVID-19 guidance has never recommended decontamination of respirators.³⁷¹ Respirators should be discarded if they become moist, visibly soiled, damaged, or become hard to breathe through. The ECDC recommends that, where reuse of respirators is considered as a last resort option to economise on use of PPE, the risk of the surface of the respirator becoming contaminated by respiratory droplets is considered to be lower when it is covered with a visor.³⁸³ However this ensemble is dependent on a plentiful supply of visors.

As highlighted in the ECRI report, the reported pathogen transfer risk from contact during donning and doffing during reuse was considered to be higher than the risk from sessional wear.³⁷³ Unfortunately there is no evidence available to assess the impact on filtration efficacy or the risk of transmission associated with reuse of RPE in clinical settings. A study that assessed efficacy of type IIR FRSMs and N95 respirators that were worn sessionally and reused did not include a reliable control group for comparison which prevented assessment of the efficacy of continuous wear/reuse.³⁸⁴ RPE was reported to be stored between shifts in a paper bag in lockers; the extent of reuse was not reported. Compared with continuous use of FRSMs, respirators were associated with more problems for the wearer including significantly greater discomfort, trouble communicating with the patient, headaches, difficulty breathing, and pressure on the nose.³⁸⁴ The WHO '*Rational use of PPE for COVID-19*' mentions that respirators can and have previously been used for extended periods of time to treat multiple patients with the same diagnosis.³⁸⁵ Whilst WHO state that there is evidence to support respirators maintaining their protection over longer periods of time, it may not be comfortable to use one respirator for longer than 4 hours and this should be avoided³⁸⁵ as reuse may increase the potential for contamination and contact transmission of infectious agents (not just SARS-CoV-2). This risk must be balanced against the need to provide respiratory protection for HCWs providing care and to those performing AGPs. To reduce the risk of transmission associated with PPE reuse it is essential that HCWs demonstrate stringent compliance with all other infection control precautions, hand hygiene, and environmental decontamination. Irrespective of the measure implemented, HCWs must have IPC education and training on the correct use of PPE and other IPC precautions, including demonstration of competency in appropriate procedures for donning and doffing PPE and hand hygiene. These issues are for consideration by the Health and Safety Executive (HSE). The HSE approved the sessional use and reuse of PPE in the UK for COVID-19 and expects NHS Boards to have an agreed action plan that includes consideration of all measures to manage usage effectively.

Conclusion:

- PPE should be single-use unless otherwise stated by the manufacturer.
- Continuous use of surgical face masks in clinical areas (or face coverings in non-clinical areas) is required in line with physical distancing measures to reduce the risk of source transmission.
- In periods of PPE shortages, sessional use of respirators is preferred over reuse.
- In periods of PPE shortages, the decision to reuse PPE (respirators, fluid-resistant gowns or coveralls, goggles and face visors) should be based on a risk assessment considering the care activities, patient population, and the state of the PPE in question.

6 Hand hygiene

Most articles identified recommend that hand hygiene should be performed, however many do not specify the product(s) to be used in preventing the transmission of SARS-CoV-2. A number of guidance documents provide specific recommendations which differ only slightly.^{8, 12, 16} WHO and Public Health England support the use of soap and water, and alcohol-based hand rub (ABHR) when soap and water is not available and when hands are not visibly soiled.^{12, 16} Experimental evidence has shown that commercially-available ABHRs and WHO ABHR formulations are effective at inactivating SARS-CoV-2 within a contact time of 30 seconds.^{386, 387} Commercially-available ABHRs have also shown efficacy against other coronaviruses included SARS-CoV and MERS-CoV.^{386, 388}

Conclusion:

- Hand hygiene should be performed with soap and water or, when hands are not visibly soiled, with ABHR.

7 Survival in the environment

A number of environmental sampling studies of rooms/areas occupied by COVID-19 patients and surrounding areas sampled various locations prior to environmental cleaning; viral RNA was found on multiple surfaces including the bed, bed sheets, bed rail, locker, chair, light switches, sink, taps, floor and staff shoes, window ledge, PPE storage area, hand sanitiser dispensers, air outlet fans, elevator buttons, as well as the toilet bowl surface and handle, door handle, and medical equipment (ventilators, monitors, blood pressure cuffs, thermometers, drainage bags, high flow oxygen generator, endotracheal tube, infusion pumps).^{18-21, 23-27, 29, 31-34, 37, 38, 323, 389-395} Personal items such as mobile phones, TV remotes, towels and toothbrushes were also contaminated.^{19, 31, 37, 38, 390} Overall, positive rates were significantly higher in medical areas compared to office areas and buffer rooms for donning PPE; contamination in these areas was found on telephones, desktops, keyboards, computer mice and water machine buttons.^{24, 395} Sampling carried

out prior to environmental cleaning across patient care areas and non-patient care areas of an emergency department revealed positive samples in patient care areas only (from stretchers, pulse oximeters, blood pressure cuffs, plastic screens between patients, and the floor).³⁹⁶ A study that sampled multiple surfaces within an emergency triage unit and a sub-intensive care ward identified positive samples on 2 CPAP helmets only.³⁹⁷ It is possible that environmental cleaning, carried out 4 hours prior, may have impacted results. Environmental sampling studies are often limited as they omit information regarding frequency of environmental cleaning, or conduct sampling immediately following cleaning.^{398, 399} Viable virus has been detected in one study from samples collected from the surfaces of fixtures, fittings and medical equipment in COVID-19 patient rooms¹⁹ but most studies have failed to demonstrate viability.^{33, 37, 395, 397} The potential effect of disease progression and viral shedding on environmental contamination has not been investigated extensively, however one study has demonstrated a significant correlation between viral load ranges in clinical samples and positivity rate of environmental samples ($p < 0.001$).⁴⁰⁰ When the viral load of clinical samples was higher than or equal to 3 log copies/ml, environmental contamination with SARS-CoV-2 could be detected. However, the sample size in this study was small and further research is required to confirm these findings. Environmental contamination was detected in two hotel rooms occupied by quarantined cases that were pre-symptomatic during their stay, which highlights the risk of environmental contamination from shedding in the pre-symptomatic phase.⁴⁰¹ In general, sampling studies highlight the potential for environmental contamination, particularly of frequently-touched areas, but the risk of acquiring infection from contaminated environmental sites remained unknown. An in-vivo study tested the viability of SARS-CoV-2 under a number of experimental conditions and found that cells remained viable for 3-5 days at room temperature.⁴⁰² In light of limited data for SARS-CoV-2 regarding survival time in the environment, evidence was assessed from studies conducted with human coronaviruses including MERS-CoV and SARS-CoV, and human coronavirus 229E. From largely experimental studies, human coronaviruses are capable of surviving on inanimate objects and can remain viable for up to 5 days at temperatures of 22-25°C and relative humidity of 40-50% (which is typical of air conditioned indoor environments).^{11, 95, 403-406} Experimental evidence indicates that SARS-CoV-2 survival in the environment is negatively impacted by increasing temperature.^{407, 408} Survival is also dependent on the surface type.⁴⁰³ Experimental studies using SARS-CoV-2 strains have reported viability on plastics for up to 93 hours, for 48 hours on stainless steel, 44 hours on glass, and up to 8 hours on copper.^{409, 410} Viability was quantified by end-point titration on Vero E6 cells. An experimental study conducted with human coronavirus 229E found that the virus persisted on Teflon, PVC, ceramic tiles, glass, and stainless steel for at least 5 days (and 3 days for silicon rubber) at 21°C and a relative humidity of 30-40%.⁴¹¹ Infectivity of the persistent viral cells was demonstrated experimentally using a plaque assay, however the infectivity of surface-contaminating SARS-CoV-2 in real-life conditions remains unknown. Experimental testing in the dark (zero UV) found that SARS-CoV-2 could survive for prolonged periods on multiple surface types however the negation of UV is not representative of real-life scenarios and the results of such experiments must be interpreted with caution.⁴¹²

Survival of human coronaviruses and surrogates in water is influenced by temperature (viral inactivation increases with increasing temperatures) and organic or microbial pollution.⁴¹³ A 99.9% viral titre reduction was observed after 2-3 days in waste water in an

experimental study using human coronavirus 229E, suggesting low survivability in waste water.⁴¹⁴ Samples taken from the treated sewage outlets of a number of COVID-19 Chinese hospitals were negative.^{415, 416} Samples taken (with varying methodology) from external water treatment plants in the Netherlands, France, Spain, and the US tested positive in line with the detection of cases in the population which suggests that RT-PCR analysis of sewage could be a potential surveillance tool.⁴¹⁷⁻⁴²³ Testing of sewage treatment works is now being carried out by the Scottish Environment Protection Agency (SEPA) to determine if such data exists to generate a surveillance system. There is currently no evidence that COVID-19 is transmitted from sewage or contaminated drinking water.⁴²⁴

Conclusion:

- Due to the uncertainty regarding the environmental survivability of SARS-CoV-2 in real-life conditions, it is essential that the environment is clutter free and frequency of routine cleaning is increased, particularly frequently-touched surfaces.

8 Environmental decontamination

Evidence for cleaning of the care environment for COVID-19 is limited; studies that evaluate the susceptibility of coronaviruses to cleaning/disinfectant products differ by their methodology and often use animal coronaviruses in experimental conditions.^{95, 388, 403} An experimental study using a SARS-CoV isolate, tested three different surface disinfectants but all required over 30 minutes exposure time to inactivate the virus to levels below detection.³⁸⁸ Limited evidence suggests that coronaviruses are susceptible to chlorine-based disinfectants and ethanol-based antiseptics.^{403, 425, 426} Kampf et al summarised the efficacy of various disinfectants against both human and animal coronaviruses and found that a concentration of 0.1% sodium hypochlorite was effective in 1 minute and, for the disinfection of small surfaces, 62-71% ethanol revealed a similar efficacy.⁴⁰³ Experimental testing has shown SARS-CoV-2 on inanimate surfaces (stainless steel, plastic, glass, PVC, cardboard) can be inactivated by 70% ethanol, 70% isopropanol, and 0.1% hydrogen peroxide.⁴²⁶ Specifically, complete inactivation was observed in 30 seconds with ethanol and isopropanol, and in 60 seconds with 0.1% hydrogen peroxide; complete viral inactivation on cotton fabric was observed after 30 seconds with 0.1% sodium laureth sulphate, which is a surfactant present in almost all household cleaning/ personal hygiene agents (e.g. dishwashing liquid, hand soaps and shampoos).⁴²⁶ Unfortunately there is a paucity of evidence regarding the efficacy of detergents at deactivating SARS-CoV-2, and due to the novel nature of this infectious agent there is an assumption that only disinfectants will be effective. The WHO recommends that, for coronaviruses, commonly used hospital-level disinfectants such as sodium hypochlorite (at a concentration of 0.5%) are effective for cleaning environmental surfaces, and 70% ethanol is suitable for disinfecting small surfaces.¹⁶ A sampling study found that twice daily cleaning of frequently-touched areas using 5000 ppm of sodium dichloroisocyanurate (a source of free chlorine) resulted in negative swab results for COVID-19 in isolation rooms that had just been cleaned; samples taken from rooms prior to cleaning had multiple positive samples

from frequently-touched areas.³⁸⁹ Similar results were reported from a Chinese hospital in which surfaces were routinely wiped with 1000 mg/L chlorine-containing disinfectant every 4 hours in isolation ICUs and every 8 hours in general isolation wards; none of the environmental samples in these areas tested positive for SARS-CoV-2 contamination.⁴¹⁵ Negative results were also found from sampling of 90 surfaces following disinfection in a Wuhan hospital dedicated to treating COVID-19 patients, in which a comprehensive environmental decontamination protocol was implemented.²⁶⁰ It consisted of chlorine dioxide air disinfection 4 times a day for 2 hours at a time in COVID-19 wards, irradiation of empty wards with UV light once per day for 1 hour, ultra-low volume spraying of chlorine dioxide (500mg/L) for air disinfection in public areas, and surfaces/objects were 'wrapped' with chlorine-containing disinfection solution (1000mg/L) twice a day.

For situations where health and care settings are at capacity and/or have no breaks in admissions or bed occupancy, the opportunity to conduct a terminal clean or a deep clean may be limited. Solutions to this may include modification to the deep clean regime to allow as high a level of decontamination to be carried out during constant occupancy as possible.

In light of the concern raised regarding aerosol transmission following the identification of positive air samples from hospital rooms,^{27, 28, 37, 389} alternative decontamination techniques that offer air decontamination should be explored. Air disinfection using ultraviolet-C light, termed ultraviolet germicidal irradiation (UVGI) is accomplished via several methods: irradiating the upper-room air only, irradiating the full room (when the room is not occupied or protective clothing is worn), and irradiating air as it passes through enclosed air-circulation and heating, ventilation, and air-conditioning (HVAC) systems.⁴²⁷ UVGI is also used in self-contained room air disinfection units. The overarching limitation of most UVGI systems is that the room must be vacated whilst disinfection is taking place; any reductions in aerosol/surface contamination will be short-lived as once the room is re-occupied, potentially infectious viral particles may again be circulating. UVGI air decontamination should therefore not be used as a replacement for optimum ventilation provision, however it may have a future use for terminal decontamination and/or in rooms in which AGPs are carried out where improvements to the existing ventilation provision are not possible. One before/after observational study that tested a UVC robot within an American long term care facility had respiratory system infection rates as an outcome measure however the methodological limitations meant that causation could not be proven; there was no certainty that the observed respiratory system infection rate decreases were due to the UVC treatment alone (and not in part due to the manual cleaning that preceded the UCGI treatment).⁴²⁸ A number of experimental studies have tested the efficacy of UVGI (specifically UVC) at inactivating SARS-CoV-2;⁴²⁹⁻⁴³³ all of the experimental studies reported on surface decontamination, none of the studies assessed air decontamination. It was not possible to summarise the collective findings of these studies due to the heterogeneity in methodology; the dose of UV, duration of exposure, and distance between the lamp and test isolate varied. Individually, these studies demonstrated efficacy under their varying experimental conditions, suggesting that further research into UVC decontamination of SARS-CoV-2 is warranted in real-life trials. A review of UV decontamination technology by HPS recommended that UV light systems can be used as an additional measure when performing terminal room decontamination.⁴³⁴ However, as surface cleaning is required prior to UVC disinfection, UVC technology will

not offer any time-saving benefits and can only be seen as an adjunct to standard environmental decontamination.

The latest version of the UK IPC guidance advises that low risk (green) COVID-19 pathways can revert to general purpose detergents for routine cleaning, as opposed to widespread use of disinfectants. The Scottish COVID-19 addendum further advises that the use of general purpose detergent for cleaning in the low risk pathway is sufficient with the exception of isolation/cohort areas where patients with a known or suspected infectious agent are being nursed.³⁶⁸

Conclusion:

- Frequency of environmental cleaning/decontamination in all health and care settings should be increased to at least twice daily, focusing on frequently-touched areas.
- A general purpose detergent should be used for routine cleaning in low risk (green) pathways and in health and care settings that are COVID-19-free.
- A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)) should be used for transmission-based environmental decontamination as per the NIPCM, in medium- and high-risk COVID-19 pathways and any settings experiencing cases/outbreaks. Small surfaces, and those which cannot be cleaned by chlorine-based agents, can be disinfected with 70% ethanol.
- Where terminal cleaning cannot be carried out due to constant occupancy, a modified enhanced clean should be carried out where possible.
- Further research is required to determine the effectiveness of UVC technology for decontamination of SARS-CoV-2.

9 Areas for further research

An overarching limitation of all identified evidence is the novel nature of SARS-CoV-2 and the limited ability for robust research at the early stages of an outbreak.

More work is needed to improve and develop culture techniques to allow determination of the viability of viral particles detected in clinical and environmental samples. This will assist with determination of the infectious dose and will provide insight into the duration of infectivity, particularly in relation to the prolonged viral shedding that is observed in faecal samples.

Further research is required to determine the extent of atypical presentations, pre-symptomatic, and asymptomatic transmission and the overall impact of these on transmission. A robust epidemiological evidence base will assist with the development of infection control measures that are targeted and evidence-based.

Assessment of the efficacy of UVGI and other novel decontamination technologies for environmental decontamination and for the decontamination of PPE would inform COVID-19 IPC guidance and provide reassurance for health and care workers.

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Appendix 1

The search terms for searches conducted from March 5th until 14th September were as follows:

1. COVID-19.mp.
2. SARS-CoV-2.mp.
3. 2019-nCoV.mp.
4. novel coronavirus.mp.
5. exp coronavirus/
6. 1 or 2 or 3 or 4 or 5
7. exp infection control/
8. exp disinfection/
9. exp decontamination/
10. exp personal protective equipment/
11. surgical mask?.mp.
12. hand hygiene.mp.
13. clean*.mp.
14. transmission.mp.
15. 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15
16. 6 and 16
17. limit 17 to English language
18. limit 18 to yr="2020 -Current"

Search terms for 21st September onwards were as follows:

1. (coronavirus or corona virus or ncov* or covid* or 2019-ncov or ncov19 or ncov-19 or 2019-novel CoV or sars-cov2 or sars-cov-2 or sarscov2 or sarscov-2 or Sars-coronavirus2 or Sars-coronavirus-2 or SARS-like coronavirus* or coronavirus-19 or covid19 or covid-19).mp.
2. infection control.ti,kw,ab.
3. disinfection.ti,kw,ab.
4. decontamination.ti,kw,ab.
5. personal protective equipment.ti,kw,ab.
6. ppe.ti,kw,ab.
7. surgical mask*.ti,kw,ab.

8. respiratory protective device*.ti,kw,ab.
9. respirator.ti,kw,ab.
10. FFP3.ti,kw,ab.
11. eye protective device*.ti,kw,ab.
12. goggles.ti,kw,ab.
13. face shield*.ti,kw,ab.
14. visor*.ti,kw,ab.
15. safety glasses.ti,kw,ab.
16. hand hygiene.ti,kw,ab.
17. clean*.ti,kw,ab.
18. transmission.ti,kw,ab.
19. 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18
20. 1 and 19
21. limit 20 to english language
22. limit to human
23. limit 22 to dd= _____ - _____

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